

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0050727

7076

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED JAN 17 1964

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF
Wallace P. Mc Keel MEDICAL CERTIFICATION

| | | | |
|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | c. CITY OR TOWN Kansas City | |
| Length of stay in 1b life | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital | | d. STREET ADDRESS (If outside, give location) 5424 Tracy | |
| 3. NAME OF DECEASED (Type or print) First STEPHEN Middle SYLVESTER Last BURNETT | | 4. DATE OF DEATH Month December Day 30 Year 1963 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3-14-1883 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Clerk | | 11. BIRTHPLACE (City and state or country) Kansas City, Missouri | |
| 13a. FATHER'S NAME Michael E. Burnett | | 14. NAME OF HUSBAND OR WIFE none | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Mrs. Thomas L. Ryan | | Address 5424 Tracy | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Cerebral Thrombosis. DUE TO (b) Cerebral arteriosclerosis. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH Immediate | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Possible Generalized malignancy | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ | |
| 21. I attended the deceased from 12/12/63 to 12/30/63 and last saw him alive on 12/29/63 Death occurred at 3:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22. SIGNATURE (Degree or title) Wallace P. Mc Keel M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-2-64 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 23d. LOCATION (City, town, or county) Kansas City, Missouri | |
| 24. FUNERAL DIRECTOR Melody-McGilley-Eylar | | 25. DATE RECD. BY LOCAL REG. 12-30-63 | |
| 26. REGISTRAR'S SIGNATURE Bessie Smith | | 27. DATE SIGNED 12/30/63 | |

USE BLACK INK

OR

TYPEWRITER RIBBON

5210200

Mr. Walter Mc Kee
4320 Hornall

~~Wa 1-4626~~

Mon: L01-1533

2:00 to 5:00

STATEMENT BY LICENSED EMBALMER

0-22

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James E. Hackleman

Licensed Embalmer No. 4523

P. O. Address 150 Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.